STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155383	B. WIN	G		03/28/	2012
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON ST		
WASHINGTON HEALTH CARE CENTER				INDIAN	APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG				TAG			DATE
K0000							
			17.00	200			
	_	de Recertification and	K00	000			
		Survey was conducted by					
	the Indiana State	Department of Health in					
	accordance with	42 CFR 483.70(a).					
	Survey Date: 03	/28/12					
	Facility Number:	: 000393					
	Provider Number: 155383						
	AIM Number: 100289340						
	THIS I (dilloc). I	002073.10					
	Surveyor: Mark	Caraher, Life Safety					
	Code Specialist	Caraner, Ene Salety					
	Code Specialist						
	At this Life Cofe	tr. Codo aumior					
	At this Life Safet						
	_	Ith Care Center was					
	found not in com	•					
	Requirements for	•					
		aid, 42 CFR Subpart					
	· /·	afety from Fire and the					
	2000 Edition of t						
	Protection Assoc	eiation (NFPA) 101, Life					
	Safety Code (LS	C), Chapter 19, Existing					
	Health Care Occ	upancies and 410 IAC					
	16.2.						
	This one story fa	cility was determined to					
	_	1) construction and fully					
		facility has a fire alarm					
	_	ke detection in the					
		open to the corridors and					
	-	oms. The facility has a					
	m an resident 100	oms. The facility has a					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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	of Correction identification number: 155383	(X2) MULTIPLE CO. A. BUILDING B. WING	01	COMPLETED 03/28/2012		
	PROVIDER OR SUPPLIER GTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COMPLETION		
	capacity of 94 and had a census of 84 at the time of this visit.					
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/03/12.					
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
This Think of Column	.011011	155383	A. BUII			03/28/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER	OR SUPPLIER				WASHINGTON ST		
WASHINGTON H	IEALTH CA	RE CENTER	INDIANAPOLIS, IN 46231				
` ′		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
`		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
Doors than i exits, doors solid-resist sprink resist imped Doors keepi meeti Rolled regula Based facility room frame. affect vicinit Findin Based Mainte the fact on 03/4 the confailed frame on interest the Mainte the	sAFETY C is protecting required entering required entering required entering fire for a sklered build in the passage diment to the sare providing the door ing 19.3.6.3 in latches are ations in all on observations on observations of Roomers and the same provided in the same provided any residency of Roomers and the same state of the sa		K00	018	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? The latching mechanism for the corridor door was repaired on 4/9/12, with door repair enabling door to latch into the door frame when the door is closed. How you identify other Residents having the potential to be affect by the same deficient practice and what corrective action will taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The latching mechanism for the corridor door was repaired on 4/9/12, with the door repair enabling door to latch into the door frame when the door is closed. All doors protecting corridor openings, such as resident room doors or applica	nts / ng ne will tted be ting fed e.	04/23/2012

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PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155383	(X2) MULTIPLE CON A. BUILDING	01 	COMPLETED 03/28/2012		
	PROVIDER OR SUPPLIER	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST				
	GTON HEALTH CARE CENTER		POLIS, IN 46231	- Company		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	(X5) COMPLETION DATE		
	corridor door to resident Room 205 failed to latch into the door frame when the door was closed. 3.1-19(b)		doors, will be reviewed by 4/18 to ensure the door latches into the door frame when the door closed. What measures will put into place or what systema changes will you make to ensuthat the deficient practice does not recur? All doors protecting corridor openings, such as resident room doors or applica doors, will be reviewed by 4/18 to ensure the door latches into the door frame when the door closed. An inservice for all stawill be completed by 4/23/12 to educate staff on awareness of requirement for resident room doors to latch into the door frawhen the door is closed. A Lif Safety Review audit tool will be utilized weekly x 4 weeks, monthly x 2, and quarterly thereafter. How the correctivaction(s) will be monitored to ensure the deficient practice wonot recur, i.e. what quality assurance program will be put into place? A Life Safety Revaudit tool will be utilized by Maintenance Supervisor week 4 weeks, monthly x 2, and quarterly thereafter to ensure doors latch into the door frame when the door is closed. The Quality Assurance committee when the door is closed. The Quality Assurance committee when the door doors latch into the door frame when the door is closed. The Quality Assurance committee when the door is closed. The Quality Assurance committee when the door doors latch into the door frame when the door is closed. The Quality Assurance committee when the door is closed. The Quality Assurance committee when the door doors latch into the door frame when the door is closed. The Quality Assurance committee when the door is closed. The Quality Assurance committee when the door doors latch into the door frame when the door doors latch into the door frame when the door doors latch into the door frame when the door doors latch into the door frame when the door doors latch into the door frame when the door doors latch into the door frame when the door latch and the later and	is be stic ure is a stic ure i		

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Event ID: IKCV21

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155383	A. BUII B. WIN			03/28/2012	
			b. why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			WASHINGTON ST		
WASHING	GTON HEALTH CA	RE CENTER		INDIANAPOLIS, IN 46231			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0025	NFPA 101	005 07440					
SS=E		ODE STANDARD					
		are constructed to provide at nour fire resistance rating in					
		8.3. Smoke barriers may					
		atrium wall. Windows are					
		-rated glazing or by wired					
	• .	steel frames. A minimum of					
		mpartments are provided on					
	•	pers are not required in duct					
	penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4						
		ation and interview, the	K00	25	What corrective action(s) will b		04/23/2012
	facility failed to	ensure 1 of 1 openings			accomplished for those reside		
	through the ceilin	ng into the attic above the			found to have been affected by the deficient practice? The three foot by fifteen inch hold in the		
	boiler room was	maintained to provide at					
		our fire resistance rating.			ceiling in the boiler room was		
		actice could affect any			repaired and firestopped on		
	•	visitor in the vicinity of			4/9/12 by maintenance staff.		
	the boiler room.	visitor in the vicinity or			building review was completed 4/912 with no further concerns		
	the boner room.				smoke barriers identified.	• 111	
	Din din an in alada				How will you identify other		
	Findings include	•			Residents having the potential	to	
	D 1 1	at talia			be affected by the same defici-	ent	
	Based on observa				practice and what corrective	1.	
		pervisor during a tour of	1		action will be taken? Resident	ts .	
	•	11:40 a.m. to 2:20 p.m.			currently living in the facility, visitors, and staff have the		
	on 03/28/12, then	re is a three foot by			potential to be affected by the		
	fifteen inch hole	in the ceiling in the			alleged deficient practice. The	;	
	boiler room which	ch is not firestopped.			three foot by fifteen inch hold i	n	
	Based on intervie	ew at the time of			the ceiling in the boiler room w	/as	
		Maintenance Director	1		repaired and firestopped on	^	
	· ·	ak this past winter			4/9/12 by maintenance staff. A		
		ling causing the hole in			building review was completed on 4/912 with no further areas		
	•	9			identified.		
	me cening and ac	cknowledged there is a	1		What measures will be put into		
			1		·		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155383	A. BUILDING B. WING		01 	COMPLETED 03/28/2012	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WASHIN	GTON HEALTH CA	RE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	three foot by fifte	een inch hole in the ler room which is not			place or what systematic chanwill you make to ensure that the deficient practice does not reconstructed. When repairs or building dama occurs in the future, facility will review areas to ensure these area are maintained to provide least one half hour fire resistar rating. Another building review will by conducted by 4/23/12 to ensure smoke barriers are being maintained to provide at least one half hour fire resistance rating. An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of smoke barriers. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter. How the corrective action(s) who be monitored to ensure the deficient practice will not recurrice, what quality assurance program will be put into place? Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly 4, monthly x 2, and quarterly thereafter to ensure smoke barriers are constructed and maintained to provide at least one half hour fire resistance rating. The CQI committee will review the data. If 90% thresh is not achieved, an action plan be developed.	e ur? age at ace vong a forf x ill , A x a l old	

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Event ID: IKCV21

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		155383	A. BUII B. WIN			03/28/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIER	L Company of the Comp			WASHINGTON ST		
WASHING	GTON HEALTH CA	RE CENTER		INDIANAPOLIS, IN 46231			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	NFPA 101 LIFE SAFETY Corone hour fire rate fire-rated doors) fire extinguishing 8.4.1 and/or 19.3 areas. When the extinguishing system are self-closing a protective plates inches from the begin permitted. 19.3 Based on observation facility failed to deserving hazardour rooms greater that used to store comprovided with sections and latch the frame. This defication affect any resident vicinity of the Corone. Findings include Based on observation from the Corone facility from on 03/28/12, the Central Supply stepping with a statch the door into the corone for the corone facility from on 03/28/12, the Central Supply stepping with a statch the door into the corone for the corone facility from on 03/28/12, the Central Supply stepping with a statch the door into the corone for the	ODE STANDARD ed construction (with ¾ hour or an approved automatic g system in accordance with 3.5.4 protects hazardous e approved automatic fire stem option is used, the ated from other spaces by partitions and doors. Doors and non-rated or field-applied that do not exceed 48 bottom of the door are 3.2.1 ation and interview, the ensure 1 of 8 doors as areas such as storage an fifty square feet in size abustible materials are If closing devices to an door into the door cient practice could ant, staff or visitor in the entral Supply storage	K00		What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? A new self-closing device was installed on the Central Supply storage room on 4/9/12. How will you identify other Residents having the potential to be affected by same deficient practice and who corrective action will be taken? Residents currently living in the facility, visitors, and staff have potential to be affected by the alleged deficient practice. A review of storage rooms and other doors was performed on 4/9/12 to ensure these doors serving areas that may be hazardous or store combustiblitems has a self-closing device. Another review will be completed by 4/23/12 to ensure doors serving areas that may be hazardous or store combustiblitems have self-closing device. What measures will be put into place or what systematic chan	ed u g the hat e the	04/23/2012

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PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/28/2012			
	PROVIDER OR SUPPLIER GTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			
	165 square feet and is used to store combustible boxes and diapers. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Central Supply storage room measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a self closing device. 3.1-19(b)		will you make to ensure that the deficient practice does not reconditional Another review will be completed by 4/23/12 to ensure doors serving areas that may be hazardous or store combustibilitems have self-closing device. An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of need self-closing devices on applications. A Life Safety audit tool be utilized by Maintenance Supervisor or designee weekly 4, monthly x 2, and quarterly thereafter. When renovation or repairs occur in the future, faci will review areas to ensure the areas are maintained to provide self-closing device on doors serving applicable areas that in contain hazards or store combustible items. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter to ensure doors serving areas the may be hazardous or store combustible items have self-closing device. The CQI committee will review the data 90% threshold is not achieved action plan will be developed.	e date date date date will / X or dility see de may ent t date X at			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1			ETED	
		155383	B. WIN			03/28/2	2012
NAME OF D	PROVIDER OR SUPPLIER		•	STREET .	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			8201 W	/ WASHINGTON ST		
	GTON HEALTH CA	RE CENTER		INDIAN	IAPOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG K0038	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
SS=E	_	ODE STANDARD					
30-L		ranged so that exits are					
		e at all times in accordance					
	with section 7.1.	19.2.1					
		ation and interview, the	K00)38	What corrective action(s) will be		04/23/2012
	facility failed to	ensure the means of			accomplished for those resider found to have been affected by		
	egress through 1	of 5 delayed egress locks			the deficient practice? On 4/2/	' I	
	was readily acces	ssible for residents, staff			a readily visible and durable si		
	and visitors. LSO	C 7.2.1.6.1, Delayed			was placed adjacent to the		
	Egress Locks, sa	ys approved, listed,			reading PUSH UNTIL ALARM		
	delayed egress lo	ocks shall be permitted to		SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. A			
	be installed on doors serving low and ordinary hazard contents in buildings				more permanent readily visible		
					and durable sign will be placed	t l	
	protected through	hout by an approved,			adjacent to release device on door by 4/23/12. How will you identify other Residents having the potential to be affected by the same deficient practice and what		
	supervised auton	natic fire detection					
	system installed	in accordance with					
	Section 9.6, or ar	n approved, supervised					
	automatic sprink	ler system installed in			corrective action will be taken?		
	_	Section 9.7, and where			Residents currently living in the facility, visitors, and staff have		
	permitted in Cha	pters 12 through 42,			potential to be affected by the	uie	
	-	On the door adjacent to			alleged deficient practice. On		
		e, there shall be a readily			4/2/12 a readily visible and		
		ign in letters not less			durable sign was placed adjac	ent	
	· ·	and at least 1/8 inch in			to the reading PUSH UNTIL ALARM SOUNDS. DOOR CA	_N	
	_	a contrasting background			BE OPENED IN 15 SECONDS		
	that reads:	<i>U</i>			A more permanent readily visit		
		LARM SOUNDS.			and durable sign will be placed	t	
	DOOR CAN BE				adjacent to release device on door by 4/23/12. What		
	SECONDS				measures will be put into place	or	
		actice could affect any			what systematic changes will y	ou/	
	*	visitor wanting to exit			make to ensure that the deficie	ent	
	•	ing the front lobby exit.			practice does not recur? An		
			inservice for all staff will be completed by 4/23/12 to educa		ate		
	Findings include				staff on awareness of delayed		
	1 mam55 merade	•	- 1		1		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		A. BUILDING B. WING			COMPLETED 03/28/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	the facility from on 03/28/12, the equipped with a which can be operated force to the release seconds but the exprovided with sign could be opened on the door. Bastime of observations Supervisor acknowled exit door is equipped egress lock but the lawer signage states opened within 15	pervisor during a tour of 11:40 a.m. to 2:20 p.m. front lobby exit door is delayed egress lock ened by the application of se device within 15 exit door was not gnage stating the door in 15 seconds by pushing sed on interview at the on, the Maintenance owledged the front lobby oped with a delayed the exit door does not ting the door can be			egress on applicable doors. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice w not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter to ensure delayed egress doors marked with PUSH UNTIL ALARM SOUND. DOOR CAN BE OPENED IN 15 SECONDS The CQI committee will review the data. If 90% threshold is n achieved, an action plan will be developed.	/ x vill t x		

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Event ID: IKCV21

Facility ID: 000393

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155383	A. BUILDING	01	COMPLETED 03/28/2012
		133363	B. WING	ADDRESS STEEL STATE STATE STATE	03/20/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST	
WASHIN	GTON HEALTH C	ARE CENTER		NAPOLIS, IN 46231	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		R LSC IDENTIFTING INFORMATION)	TAG	BEITEIENCTY	DATE
K0050 SS=F	Fire drills are he varying condition shift. The staff and is aware the routine. Responsive conducting drills competent persecencise leader conducted between announcement audible alarms. Based on record facility failed to conducted on the quarters. This call occupants in residents, staff afformation of the maintenance Sureview from 9:203/28/12, document available for review from 9:203/28/12, document available for review and the maintenance acknowledged to documentation affire drill being of the staff and the maintenance acknowledged to documentation affire drill being of the staff and the maintenance acknowledged to documentation affire drill being of the staff and	I review and interview, the document fire drills e second shift for 2 of 4 deficient practice affects the facility including and visitors. e: v of "Monthly Fire Drill entation with the apervisor during record 0 a.m. to 11:40 a.m. on mentation was not view for a fire drill e second shift for the d quarters of 2011. Based the time of record review, e Supervisor	K0050	What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? Fire drivill be conducted at least quarterly on each shift, at unexpected times under varying conditions. How will you ident other Residents having the potential to be affected by the same deficient practice and we corrective action will be taken? Residents currently living in the facility, visitors, and staff have potential to be affected by the alleged deficient practice. Fire drills will be conducted at least quarterly on each shift, at unexpected times under varying conditions. A fire drill for secons shift will be conducted by 4/23 for second quarter of 2012. We measures will be put into place what systematic changes will make to ensure that the deficient practice does not recur? Fire drills will be conducted at least quarterly on each shift, at unexpected times under varying times.	nts y ills ills ng ntify hat e the e the //12 //hat e or you ent t

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/28/2012					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE			
	2011. 3.1-19(b)			conditions. Fire drill reports to be kept in Maintenance Supervisor office with copy of drill reports in Executive Director's office. A Life Safet audit tool for fire drills will be utilized by Maintenance Supervisor or designee week 4, monthly x 2, and quarterly thereafter to ensure the requirement is met for fire dri be conducted at least quarter each shit. How the correctiv action(s) will be monitored to ensure the deficient practice not recur, i.e. what quality assurance program will be puinto place? A Life Safety aud tool for fire drills will be utilize Maintenance Supervisor or designee weekly x 4, monthl 2, and quarterly thereafter to ensure the requirement is me fire drills to be conducted at lequarterly on each shift. The Committee will review the dat 95% threshold is not achieve action plan will be developed	If fire y lly x lls to cly on e will ut lit bd by y x et for east CQI a. If d, an			

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Event ID: IKCV21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVE COMPLETED 03/28/2012			ETED		
	PROVIDER OR SUPPLIER		<i>p. wax</i>	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0064 SS=E	Portable fire extinealth care occurs. 19.3.5 Based on observe facility failed to K class fire extincooking area in a requirements of Portable Fire Ext NFPA 10, 2-3.2 extinguishers proof cooking appliacooking media (vand fats) shall be Class K fires. Na placard shall be near the extinguing protection system to using the fire of fixed fire extinguationatically should be activate portable fire extineating automatically should be activate portable fire extines and proposed for the portable fire extines are the port	povided for the protection ances using combustible vegetable or animal oils elisted and labeled for FPA 10, 2-3.2.1 requires econspicuously placed sher which states the fire in shall be activated prior extinguisher. Since the uishing system will at off the fuel source to itance, the fixed system ed before using a inguisher. In this table fire extinguisher is offect any residents, staff or cinity of the kitchen.	K00	164	What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? A permanent placard for K class portable fire extinguisher in the kitchen was placed adjacent to class portable fire extinguisher stating the fire protection systes shall be activated prior to using the K class portable fire extinguisher. How will you identify other Residents having the potential to be affected by same deficient practice and who corrective action will be taken? Residents currently living in the facility, visitors, and staff have potential to be affected by the alleged deficient practice. A permanent placard for K class portable fire extinguisher in the kitchen was placed adjacent to class portable fire extinguisher in the kitchen was placed adjacent to class portable fire extinguisher in the kitchen was placed adjacent to class portable fire extinguisher be put into place or what systematic changes will you may to ensure that the deficient practice does not recur? An inservice for all staff will be completed by 4/23/12 to educate the requirement for K class extinguisher that fire protection	nts y e K f, em g the nat e the will ake	04/23/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	01	(X3) DATE SURVEY COMPLETED			
	155383		A. BUILDING		03/28/2012			
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER		8201 W WASHINGTON ST					
WASHIN	GTON HEALTH CARE CENT	ER	INDIANAPOLIS, IN 46231					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF THE STATE OF THE SUMMARY STATEMENT OF LSC IDENTION OF LSC IDENTION OF THE SUMMARY STATEMENT OF THE SUMARY STATEMENT	E PERCEDED BY FULL FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) system shall be activated prior	5.112			
	the facility from 11:40 a.m on 03/28/12, a placard was conspicuously placed near portable fire extinguisher fire protection system shall prior to using the K class pextinguisher. Based on in time of observation, the M Supervisor acknowledged not conspicuously placed portable fire extinguisher aprotection system shall be to using the K class portable extinguisher. 3.1-19(b)	s not the K class which states the ll be activated portable fire terview at the laintenance a placard was near the K class stating the fire activated prior		using the K class portable fire extinguisher. A Life Safety autool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter to ensure the placement of placa for K class portable fire extinguisher(s). How the corrective action(s) will be monitored to ensure the deficie practice will not recur, i.e. wha quality assurance program will put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter to ensure the placement of placa for K class portable fire extinguisher(s). The CQI committee will review the data 100% threshold is not achieve an action plan will be developed.	dit x rd ent t be x rd . If d,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	01	COMPL	ETED
		155383	B. WIN			03/28/2012	
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WASHINGTON ST		
WASHIN	GTON HEALTH CA	RE CENTER		INDIANAPOLIS, IN 46231			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	NFPA 101 LIFE SAFETY C Medical gas storare protected in a Standards for He (a) Oxygen stora 3,000 cu.ft. are e separation. (b) Locations for than 3,000 cu.ft. NFPA 99 4.3.1.1 Based on observa facility failed to storage locations cubic feet was er of 1 hour fire res deficient practice resident, staff or the oxygen storage Findings include Based on observa Maintenance Sup the facility from on 03/28/12, the transfilling room oxygen canisters	ODE STANDARD age and administration areas accordance with NFPA 99, ealth Care Facilities. age locations of greater than enclosed by a one-hour supply systems of greater are vented to the outside. 2, 19.3.2.4 ation and interview, the ensure 1 of 1 oxygen of greater than 3000 aclosed with a fire barrier istive construction. This e could affect any visitor in the vicinity of ge and transfilling room.	K00	TAG	What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? Ceiling the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to more requirement of fire barrier of 1 hour fire resistive construction. How will you identify other Residents having the potential be affected by the same deficitly practice and what corrective action will be taken? Resident currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Ceil of the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to more requirement of fire barrier of 1	e ents y of leet to ent ts ling leet	
	drywall. Based of observation, the Supervisor acknown provide one has a supervisor acknown to the supervisor acknown to th	on interview at the time			hour fire resistive construction. What measures will be put into place or what systematic chan will you make to ensure that the deficient practice does not recombe when renovation or repairs oc in the future, the facility will revenue.	ges le ur? cur	

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AND PLAN	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 03/28/2012
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN 46231	1
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) areas to ensure that there is separation of a fire barrier of 1-hour fire-resistive construct between rooms utilized for storage and transferring of oxygen. A Life Safety audit twill be utilized by Maintenand Supervisor or designee week 4, monthly x 2, and quarterly thereafter to ensure requirem of fire barrier of 1 hour fire resistive construction is maintained. How the correct action(s) will be monitored to ensure the deficient practice not recur, i.e. what quality assurance program will be puinto place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthing 2, and quarterly thereafter to ensure requirement of fire barrier resistive construction is maintained. To CQI committee will review the data. If 100% threshold is not achieved, an action plan will developed.	tion ool ce kly x nent ctive will ut dit y x rrier The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A RULL DING 01 COMPLETED			
111,12,1211,	or condition,	155383	A. BUILDING B. WING		03/28/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		V WASHINGTON ST	
WASHIN	GTON HEALTH CA	RE CENTER	INDIAN	IAPOLIS, IN 46231	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG K0143	NFPA 101	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
SS=E		ODE STANDARD			
00 L	Transferring of o				
	-				
		om any portion of a facility			
		are housed, examined, or aration of a fire barrier of			
	1-hour fire-resist				
	(b) in an area tha	at is mechanically ventilated,			
		has ceramic or concrete			
	flooring; and (c) in an area posted with signs indicating that				
	transferring is oc	curring, and that smoking in			
		rea is not permitted in			
		NFPA 99 and the s Association. 8.6.2.5.2			
	i -	ation and interview, the	K0143	What corrective action(s) will	be 04/23/2012
		ensure 1 of 1 liquid	10113	accomplished for those reside	
	*	reas where transferring		found to have been affected b	-
	''	place was separated from		the deficient practice? Ceiling	g of
		facility wherein residents		the oxygen storage and transfilling room had additional	al
		nined, or treated by a		ceiling installed on 4/9/12 to n	
	·	re barrier of 1 hour fire		requirement of fire barrier of 1	
	*	ction. This deficient		hour fire resistive construction How will you identify other	l.
		fect residents, staff and		Residents having the potentia	I to
	_	cinity of the oxygen		be affected by the same defic	
	storage and trans			practice and what corrective	
		g : 00		action will be taken? Residen currently living in the facility,	TS
	Findings include	:		visitors, and staff have the	
	<i>G</i> 2			potential to be affected by the	
	Based on observa	ation with the		alleged deficient practice. Ce of the oxygen storage and	iling
	Maintenance Sur	pervisor during a tour of		transfilling room had additiona	al
		11:40 a.m. to 2:20 p.m.		ceiling installed on 4/9/12 to n	
		oxygen storage and		requirement of fire barrier of 1	
		contained four liquid		hour fire resistive construction	
		1		What measures will be put int	°

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/28/2012
	PROVIDER OR SUPPLIER		8201 V	ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST NAPOLIS, IN 46231	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	one layer of five drywall. Based of of observation, the Supervisor acknown not provide one l	owledged the ceiling did nour fire resistive the oxygen storage and		place or what systematic char will you make to ensure that the deficient practice does not red When renovation or repairs of in the future, the facility will reareas to ensure that there is separation of a fire barrier of 1-hour fire-resistive construction between rooms utilized for storage and transferring of oxygen. A Life Safety audit to will be utilized by Maintenance Supervisor or designee weekled 4, monthly x 2, and quarterly thereafter to ensure requirement of fire barrier of 1 hour fire resistive construction is maintained. How the correct action(s) will be monitored to ensure the deficient practice who trecur, i.e. what quality assurance program will be putinto place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly 2, and quarterly thereafter to ensure requirement of fire barrof 1 hour fire resistive construction is maintained. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	ne eur? cour view on on ool e y x ent tive vill t t t

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE (COMPL 03/28 /	ETED	
	ROVIDER OR SUPPLIER GTON HEALTH CA		8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	Generators are in exercised under month in accordance 3.4.4.1.	ODE STANDARD Inspected weekly and Iload for 30 minutes per Iloance with NFPA 99. Indirection of the complete of the comple	K01	44	What corrective action(s) will be accomplished for those reside	nts	04/23/2012
	written record of the starting batter generator was may weeks. Chapter requires storage to connection with a systems shall be not more than 7 cmaintained in full manufacturer's splatteries shall be immediately upo Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a written performance, exerepairs for the gemaintained and a having jurisdiction	weekly inspections of ries for the emergency aintained for 30 of 52 3-4.4.1.3 of NFPA 99 batteries used in essential electrical inspected at intervals of			found to have been affected by the deficient practice? Gener will be inspected weekly and exercised under load for 30 minutes per month, and recorded. Emergency Generator/Load Testing log wi include percentage load capaciminimum exhaust gas temperatures, and time it takes transfer power from the main source to the emergency generator. How will you ident other Residents having the potential to be affected by the same deficient practice and will corrective action will be taken? Residents currently living in the facility, visitors, and staff have potential to be affected by the alleged deficient practice. Generator will be inspected weekly and exercised under lof for 30 minutes per month, and recorded. Recordings will percentage load capacity, minimum exhaust gas temperatures, and time it takes transfer power from the main source to the emergency	y ator Il sity, s to ify e the	
	Findings include Based on review				generator. What measures we be put into place or what systematic changes will you measure that the deficient		

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		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	01	COMPLETED
		155383	B. WIN			03/28/2012
NAME OF F	PROVIDER OR SUPPLIER	-	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-
					WASHINGTON ST	
WASHIN	GTON HEALTH CA	RE CENTER		INDIAN	APOLIS, IN 46231	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		s" documentation with			practice does not recur? Maintenance Supervisor or	
		Supervisor during			designee will conduct the wee	klv
		om 9:20 a.m. to 11:40			generator inspections, exercis	-
		, weekly emergency			under load for 30 minutes per	
	, ,	g battery inspection			month and record on Emerger	
		venty eight week period			Generator/Load Testing log. A CQI tool for Life Safety Review	
	of 04/02/11 thro	ugh 05/28/11 and			will be utilized weekly x 4 and	, , , , , , , , , , , , , , , , , , ,
	11/05/11 through	n 03/24/12 was not			monthly thereafter to ensure the	ne
	available for review. Based on interview				requirement is met. How the	•
	at the time of rec	ord review, the			corrective action(s) will be	
	Maintenance Supervisor acknowledged				monitored to ensure the defici- practice will not recur, i.e. wha	
	weekly emergend	cy generator starting			quality assurance program wil	
	battery inspection	n records for the twenty			put into place? Maintenance	
	eight week perio	d of 04/02/11 through			Supervisor or designee will	
		05/11 through 03/24/12			conduct the weekly generator	lood
	were not availab	_			inspections, exercising under for 30 minutes per month and	
					record on Emergency	
	3.1-19(b)				Generator/Load Testing log. A	
					CQI tool for Life Safety Review	v
	2. Based on reco	ord review and interview,			will be utilized weekly x 4 and monthly thereafter to ensure the	ne
		to ensure a monthly load			requirement is met for general	
		nergency generators was			inspections weekly and exerci	
		of 12 months using one			under load for 30 minutes per	
		wing methods: under			month, and recorded. The CQ committee will review the data	
		rature conditions, at not			90% threshold is not achieved	
		the Emergency Power			action plan will be developed.	.,
		meplate rating, or loading			·	
		e minimum exhaust gas				
		· ·				
	temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to					
		with NFPA 110.				
	Chapter 6-4.2 of	NFPA 110 requires				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPL 03/28/	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN 46231		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	generator sets in service to be exe monthly, for a musing one of the a. Under operating or at not less that nameplate rating b. Loading that mexhaust gas temprecommended by The date and time testing shall be desired on facility 3-5.4.2 requires a inspection, performended and repair maintained and repair maintained and a by the authority deficient practice residents, staff and Findings include Based on review Generator Check the Maintenance record review from a.m. on 03/28/12 documentation we review for the perturbed of the performance of	Level 1 and Level 2 reised at least once inimum of 30 minutes, following methods: ng temperature conditions n 30 percent of the EPS naintains the minimum beratures as of the manufacturer. the of day for required the ecided by the owner, toperations. NFPA 99, the written record of trance, exercising the shall be regularly twailable for inspection thaving jurisdiction. This the could affect all the divisitors.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL - 03/28/	ETED	
	PROVIDER OR SUPPLIER		8201 \	ADDRESS, CITY, STATE, ZIP CO W WASHINGTON ST NAPOLIS, IN 46231	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	review for the pe	rumentation available for briod of March 2011 11 and November 2011 y 2012.				
	3.1-19(b)					
	the facility failed documentation for emergency generative emergency li 7.9.2.3 and NFP. Facilities, 3-4.1.1 set(s) shall have pick up the load frequency and vor requirements of within 10 second power. This definition	rators providing power to ghting systems. LSC A 99, Health Care 1.8 requires the generator sufficient capacity to and meet the minimum				
	Findings include	:				
	documentation w Supervisor durin 9:20 a.m. to 11:4 emergency gener monthly basis fo each month for the through 10/15/11	of "Emergency ising/Load Testing" with the Maintenance g record review from 0 a.m. on 03/28/12, the rator was run on a r at least thirty minutes the period of 06/11/11 but the logs utilized by ded the time to transfer				

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	OF CORRECTION IDENTIFICATION NUMBER: 155383	A. BUILDING B. WING	COMPLETED 03/28/2012
	PROVIDER OR SUPPLIER GTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	power from the main source to the emergency generator as the time of day the load test was conducted. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the transfer time to transfer power to the emergency generator for the period of 06/11/11 through 10/15/11 was recorded as the time of day the load test was conducted and not how long it took to transfer power from the main source to the emergency generator. 3.1-19(b)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155383	B. WIN	G		03/28/	2012
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0154 SS=F	Where a required is out of service 24-hour period, to jurisdiction is not evacuated or an is provided for all the shutdown unbeen returned to Based on record facility failed to written policy confollowed in the esprinkler system service for 4 hour period in accordary 9.7.6.1 in order to the residents. LSC 9 impairment procent NFPA 25, 1998 Inspection, Testing Water-Based Firm NFPA 25, 11-5(department be not impairment and insurance carrier building owner/mauthorities having notified. This department in the defect all residents. Findings included Based on review is provided to the service of the serv	review and interview, the provide a complete intaining procedures to be event the automatic has to be placed out of its or more in a 24 hour ance with LSC, Section to protect 84 of 84 of 2.7.6.2 requires sprinkler edures comply with Edition, the Standard for ing and Maintenance of the Protection Systems. It is alarm company, manager and other ing jurisdiction also be efficient practice could its, staff and visitors.	K01	54	What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? Facility fire watch policy was updated 4/12/12. The updated Fire War policy includes notification of the lindiana State Department of Health, alarm company, local find department, and building owner the event the automatic sprink system or fire alarm system has to be placed out of service or in out of service for 4 hours or many in a 24 hour period. How will you identify other Residents having the potential to be affect by the same deficient practice and what corrective action will taken? Residents currently living the facility, visitors, and staff have the potential to be affect by the alleged deficient practice Facility's fire watch policy was updated on 4/12/12. The updated on 4/12/12. The updated Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department and building owner in the eventhe automatic sprinkler system fire alarm system has to be	nts y y 's on atch he fire er in ler as s ore cted be ing f ed ee. ated e t, nt	04/23/2012
		of "Fire Watch Policy locumentation with the			the automatic sprinkler system		

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
	155383	B. WING		03/28/2012		
		STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER		V WASHINGTON ST			
WASHINGTON HEALTH CARE CENTER			NAPOLIS, IN 46231			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG				
	Maintenance Supervisor during record		placed out of service or is out			
	review from 9:20 a.m. to 11:40 a.m. on		service for 4 hours or more in			
	03/28/12, "Procedure" states "Call 911 to		24 hour period. What measur	es		
	report the fire. The facility's ED or		will be put into place or what	and to		
	l -		systematic changes will you not to ensure that the deficient	аке		
	designee will notify all necessary		practice does not recur? All			
	entities." The facility's written fire watch		Disaster and Emergency			
	policy stated the necessary entities, which		Preparedness manuals in faci	litv		
	includes the Indiana State Department of		updated with new Fire Watch	,		
	Health, alarm company, local fire		policy by 4/23/12. All staff will	be		
	department, and building owner/manager,		inserviced by 4/23/12 on updated			
	1 -		Fire Watch policy including the	e		
	would only be notified in the event of a		requirement of notification of t	he		
	fire. Based on interview at the time of		Indiana State Department of			
	observation, the Maintenance Supervisor		Health, alarm company, local			
	stated the facility's written fire watch		department, and building own			
	policy requires notification of the		the event the automatic sprink			
	necessary entities only in the event of a		system or fire alarm system had to be placed out of service or			
	fire and acknowledged the written fire		out of service for 4 or more ho			
	_		in a 24 hour period. How the			
	watch policy does not state notification of		corrective action(s) will be			
	the Indiana State Department of Health,		monitored to ensure the defici	ent		
	alarm company, local fire department, and		practice will not recur, i.e. wha	at		
	building owner/manager in the event the		quality assurance program wil	l be		
	automatic sprinkler system has to be		put into place? A Life Safety			
	placed out of service for 4 hours or more		audit tool will be utilized by			
	in a 24 hour period.		Maintenance Supervisor or			
	ini a 24 noui periou.		designee weekly x 4 , monthly	′ X		
			2, and quarterly thereafter to			
	3.1-19(b)		ensure requirement is met for appropriate notifications of the			
			Indiana State Department of	<i>'</i>		
			Health, alarm company, local	fire		
			department, and building own			
			for any event is which automa			
			sprinkler system or fire alarm			
			system are out of service for			
			more than 4 hours in 24 hour			
			period. The CQI committee wi	II		
			review the data. If 100%			

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
	,	155383	A. BUILDING B. WING		03/28/2012
NA 25 05 5	AN OLUMBIA OF STARY			ADDRESS, CITY, STATE, ZIP CODI	[E
	PROVIDER OR SUPPLIER		8201 W	/ WASHINGTON ST	
WASHIN	GTON HEALTH CA	ARE CENTER	INDIAN	IAPOLIS, IN 46231	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	DATE	
TAG REGULATOR		OR LSC IDENTIFTING INFORMATION)	IAU	threshold is not achieved,	
				action plan will be develor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
		155383	B. WING		03/28/2012		
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID	SUMMARY S	MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
K0155 SS=F	Where a required service for more period, the author notified, and the approved fire water tentre tentre tentre tentre tentre for the service of the service	ODE STANDARD d fire alarm system is out of than 4 hours in a 24-hour brity having jurisdiction is building is evacuated or an another itch is provided for all parties by the shutdown until the fire is been returned to service.					
	facility failed to written policy confollowed in the end system has to be 4 hours or more accordance with order to protect 8 deficient practice residents, staff and Findings include Based on review and Procedure" of Maintenance Superview from 9:20 03/28/12, "Procedure report the fire. To designee will not entities." The fampolicy stated the jurisdiction, the left of the system	of "Fire Watch Policy documentation with the pervisor during record a.m. to 11:40 a.m. on dure" states "Call 911 to The facility's ED or tify all necessary cility's written fire watch authorities having Indiana State Department	K01	55	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? Facility fire watch policy was updated 4/12/12. The updated Fire Warpolicy includes notification of the Indiana State Department of Health, alarm company, local fidepartment, and building owner the event the automatic sprink system or fire alarm system has to be placed out of service or it out of service for 4 hours or may in a 24 hour period. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will taken? Residents currently living the potential to be affected by the alleged deficient practice Facility's fire watch policy was updated on 4/12/12. The update Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department	nts / / / / / / / / / / / / /	04/23/2012
would only be notified		e local fire department, otified in the event of a sterview at the time of			and building owner in the even the automatic sprinkler system fire alarm system has to be		

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED	
AND PLAN	155383	A. BUILDING 01		O3/28/2012	
	100000	B. WING		00/20/20 12	
	PROVIDER OR SUPPLIER GTON HEALTH CARE CENTER		SS, CITY, STATE, ZIP CODE SHINGTON ST LIS, IN 46231		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CRO TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIADEFICIENCY)	(X5) COMPLETION DATE	
	observation, the Maintenance Supervisor stated the facility's written fire watch policy requires notification of the necessary entities only in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health and the local fire department would occur in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b)	serv 24 h will be syster to er prace Disa Prepupda polici inserved India Heal department of the system of the syst	red out of service or is out rice for 4 hours or more in a four period. What measure the put into place or what rematic changes will you musure that the deficient citice does not recur? All aster and Emergency paredness manuals in facility at the policy including the put into place of the provided with new Fire Watch by 4/23/12. All staff will provided by 4/23/12 on upda watch policy including the purpose of the policy including the purpose of the policy including owners are the automatic sprink and building owners are the automatic sprink are placed out of service or it of service for 4 or more house the entities action (s) will be possible to ensure the deficient of service to ensure the deficient of the place? A Life Safety in the place? A Life Safety in the place of the	a es	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/28/2012	,	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST				
WASHINGTON HEALTH CARE CENTER			INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE COMP ROPRIATE DA	X5) LETION ATE	
				threshold is not achieved action plan will be develo			

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